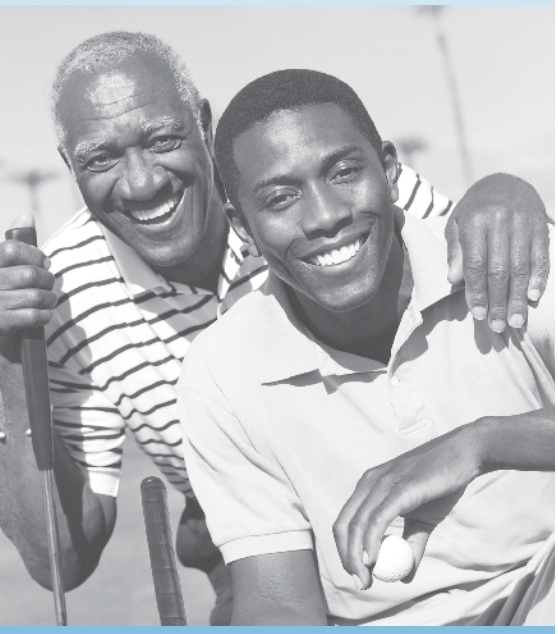
CareFirst BlueCross BlueShield



Harford County Governmental Entities

Traditional Medicare Supplemental Plan

Retirees

2007

Your Medicare Supplemental Plan

Your Protection Against Illness and High Medical Costs

Times have changed, and so have your needs. Even though you have Medicare, you still need additional health insurance to help cover your medical expenses. That's why Harford County Governmental Entities has selected the CareFirst BlueCross BlueShield Traditional Medicare Supplemental Plan for you. When you use the providers who participate with Medicare, you will have little to pay for Medicare - covered services. That way, you can just concentrate on feeling better.

Using Your Benefit Summary

This benefit summary will show you how to use the Traditional Medicare Supplemental Plan. As you read through it, you see terms such as deductible and approved amount. The definitions for these terms can be found in the Definitions Section of this book. They will help you understand how your plan can save you money and make your Medicare coverage even better than before.

This benefit summary will also tell you the following:

- What the Traditional Medicare Supplemental Plan is and how it works
- What Medicare does and doesn't cover
- When you'll need to file claims and how to file them
- How to get the most from your health care plans
- What your Traditional Medicare Supplemental benefits are

If you have any questions, just call CareFirst BlueCross BlueShield's Customer Service Department at (410) 581-3539 or (800) 342-7287. You can call between 9:00 a.m. and 5:00 p.m., Monday through Friday. A customer service representative will be happy to help you.

Your Medicare Supplemental Plan

What Your Plan Is and How It Works

1. What does the Traditional Medicare Supplemental Plan cover?

First, it covers your inpatient Medicare deductible and coinsurance, costs associated with emergency care, outpatient surgery and diagnostic services. Second, CareFirst BlueCross BlueShield will pay 80% of the difference between what Medicare pays and the Medicare approved amount (when you visit Medicare participating providers) or limiting charge (when you visit Medicare non-participating providers) for Major Medical services such as office visits and durable medical equipment.

2. How does the Traditional Medicare Supplemental Plan work?

Your Medicare coverage is always primary. That means that Medicare always pays first for Medicare - covered services. Your Traditional Medicare Supplemental Plan is your secondary plan. It provides benefits for some charges and services not covered by Medicare.

When you use a Medicare participating provider for medical services, you will have less to pay for Medicare - covered services because these providers have agreed to accept the Medicare approved amount for their services, commonly referred to as "accepting assignment."

Medicare non-participating providers do not always accept the Medicare approved amount. You will pay more for your care when you use Medicare non-participating providers.

Sometimes Medicare non-participating providers will agree to accept the Medicare approved amount for some services. Whenever they do, you will have less to pay for covered services. Please refer to questions 4 & 5 for examples.

3. How can I save money with my Traditional Medicare Supplemental Plan?

Your Traditional Medicare Supplemental Plan pays all of your up-front Medicare Part A deductibles and coinsurance amounts, regardless if you see a Medicare participating or Medicare non-participating provider.

In addition, your Traditional Medicare Supplemental Plan covers the Medicare Part B deductible for most services. In these cases, you will not have to pay the deductible, even if you see a Medicare participating or Medicare non-participating provider.

4. Why is it better to use Medicare participating providers?

When you use Medicare participating providers for Medicare and Major Medical covered services, you save money. Here's an example of a Major Medical service:

Provider's charge	$50.00
Medicare approved amount	$28.00
Medicare pays 80% of $28 approved amount (after Part B deductible)	$22.40
CareFirst pays 80% of $5.60 balance	$4.48
You pay remaining 20% coinsurance	**$1.12**

5. How much will I pay if I use Medicare non-participating providers?

Medicare non-participating providers can charge you the difference between the Medicare approved amount and the Medicare limiting balance. The difference is usually 15% more than the approved amount.

For example, a Medicare participating provider charges the approved amount for a service, say $28. A Medicare non-participating provider charges you up to the limiting charge, which would be about $32.20.

Here's an example of a Major Medical service:

Provider's charge	$50.00
Medicare approved amount	$28.00
Medicare limiting charge (15% greater than Medicare approved amount)	$32.20
Medicare pays 80% of $28 approved amount (after Part B deductible)	$22.40
CareFirst pays 80% of $5.60 balance	$7.84
You pay remaining 20% coinsurance	**$1.96**

*CareFirst's allowed benefit for services covered by Medicare and CareFirst will not exceed the Medicare approved amount/Medicare limiting charge.

6. How can I find out if a doctor is participating with Medicare?

There are three ways you can check on a doctor's participation with Medicare:

- Check the Medicare MedPar Directory (you can receive your own copy by calling Medicare)
- Call the provider directly
- Call Medicare at the following numbers

Maryland (800) 444-4606
D.C. Area (800) 444-4606
Virginia (800) 552-3423
Delaware (800) 444-4606
Pennsylvania (800) 746-5680

What Medicare Does And Doesn't Cover

1. What does Medicare cover?

Medicare has two parts, A and B. Medicare Part A (hospital insurance) partially pays for medically necessary

- inpatient hospital facility charges
- care in a skilled nursing facility after a hospital stay
- home health care provided by a Medicare – participating home health agency
- hospice care for the terminally ill

Medicare Part B (medical services insurance) partially pays for medically necessary

- physician's services
- outpatient hospital services
- home health visits
- physical and speech therapy
- services and supplies covered by Medicare, such as x-rays and durable medical equipment

2. What isn't covered by Medicare?

Medicare does not pay the full cost of all covered services. Medicare requires that you pay a share of the costs in the form of deductibles and coinsurance/copays.

When You'll Need To File Claims

You never have to submit a claim to Medicare. By law all providers must file these claims for you. And that applies to non-participating providers as well as participating providers.

1. If I receive care in Maryland, will I have to file any claims to CareFirst?

You will not have to file any claims with CareFirst for covered services if you receive the services in Maryland, Washington D.C., Delaware, New Jersey, Pennsylvania and Northern Virginia. While you may be asked to fill out claim forms for the provider, you will not have to submit the claims yourself.

CareFirst electronically receives claims from Medicare for covered services received in Maryland, Washington D.C., Delaware, New Jersey, Pennsylvania and Northern Virginia. That means that your claims automatically come to us from Medicare when you give your CareFirst membership number to your provider at the time you receive care.

Make sure that you always give your CareFirst membership number to your provider when you give your Medicare membership number. Without your CareFirst number, Medicare won't know to forward your claim information to us. You will then have to file your own claim.

2. Will I have to file any claims to CareFirst if I receive care outside of the states listed above?

Yes, your providers will file your Medicare claims for you. That's the law. But you will have to file claims with CareFirst to get benefits from your Traditional Medicare Supplemental Plan.

Here's what you should do. After Medicare has paid its share, you will receive an "Explanation of Medicare Benefits" (EOMB). Make copies of this form and of your bills for each claim. Do not send the original EOMB and medical bills. Keep the originals in your files. Claims rarely get lost, but if that should happen, you can resubmit your claim if you have kept the originals.

Send a copy of the EOMB, your bills and a completed claim form to the following address:

CareFirst Blue Cross Blue Shield
Government Accounts
10455 Mill Run Circle
Owings Mills, MD 21117

3. What if I need a claim form or help submitting a claim?

Just call your CareFirst customer service representative. The numbers to call are (410) 581-3539 or (800) 342-7287. You can also call these numbers if you want to find out if your claim has been received.

4. Is there a deadline for filing claims?

Yes, we must receive your claims by December 31 following the year in which you receive medical care.

For example, if you received care in January of 2007, you should file your claim no later than December 31, 2008.

5. What happens if my claim arrives after the deadline?

Your claim will not be covered, and you will not receive payment. So be sure to file your claim right away.

Getting The Most From Your Health Care Plan

To make sure that you make the most of your benefits and pay the least for care, follow these simple guidelines:

1. Always find out if a provider is participating (accepts the Medicare approved amount) or non-participating (does not accept the Medicare approved amount) before you receive care.

2. Avoid additional out-of-pocket expenses by using Medicare participating providers when you need Medicare-covered services

3. Always give your Medicare membership number and your CareFirst membership number when you receive care.

4. If you need to file a claim, file right away so that you don't miss the filing deadline.

Your Retail Prescription Drug Plan

With your Medicare Supplemental Plan, instead of paying in full for your prescriptions and submitting a claim for reimbursement, you will now only pay 20% up front for your prescriptions. Therefore, you will not be required to submit any claim forms.

Mail Service Prescription Drug Program Sponsored By Walgreens

A mail service prescription drug program is a special added feature to your Traditional Medicare Supplemental Plan. For those who regularly take maintenance medications, this service provides a convenient and inexpensive way for you to order these medications and have them delivered to your home.

You can order up to a 100-day supply of medication for the required copayment of $10. You must send the $10 copayment with your prescription to Walgreens. The copayment will not be reimbursed through your medical benefits.

Medications are delivered to your home postage paid via UPS or First Class U.S. Mail.

Your medications will be filled with an FDA approved generic equivalent when available.

If you have any questions regarding this prescription service, call the Walgreens toll-free patient services telephone number, Monday through Friday at (800) 745-6285.

Words You Need To Know

Approved Amount	The amount that Medicare allows participating providers to be paid for Medicare – covered services. Payments are made according to the Medicare fee schedule (see following pages). Participating providers agree to accept the approved amount as payment in full for covered services. Non-participating providers can charge you more than this amount for your care (see limiting charge). The "approved amount" also may be called the "allowed amount" or "assignment".
Coinsurance	Some services require that you pay a percentage of the costs for your medical care. For example, under Medicare Part B, you pay 20% and Medicare pays 80%. Some services require that you pay a set-dollar amount for your care. For example, under Medicare Part A, you must pay a set amount per day for inpatient hospital care after you've been hospitalized for over 60 days. Your Traditional Medicare Supplemental Plan pays the Part A coinsurance for you.
Deductibles	Some services require that you pay a deductible before Medicare begins to pay. For example, under Medicare Part A, you must pay the first $776 of your hospital bill. And under Medicare Part B, you must pay the $100 deductible for services. Then Medicare begins to pay its share.
Limiting Charge	Some providers do not accept the Medicare approved amount as payment in full for Medicare – covered services. To protect you from high charges for these services, Medicare limits the amount that these non-participating providers can bill you. The limiting charge does not apply to any of the Traditional Medicare Supplemental Plan benefits that Medicare does not cover.
Medicare Fee Schedule	In general, payments for services are made according to the standard Medicare – approved fee schedule.

Medicare Participating Providers	Physicians and suppliers who agree to always accept the Medicare approved amount as payment in full for services. (You still pay deductibles and coinsurance.) Medicare participating providers can charge you full price for services that Medicare does not cover.
Medicare Non-Participating Provider	Other physicians and suppliers who do not agree to always accept the Medicare approved amount as payment in full for services. Medicare limits the amount that non-participating providers can charge for Medicare – covered services. If you choose to see a non-participating provider, you must pay any difference between the limiting charge and the Medicare approved amount.
Provider	Any licensed doctor, nurse or professional. A provider may also be a health care facility, such as a hospital, laboratory or clinic.

Harford County Medicare Supplemental Plan

			Member Payment	
Benefits	**Remaining Costs after Medicare Payment**	**CareFirst Plan Payment**	**Provider Accepting Medicare Assignment**	**Provider Not Accepting Medicare Assignment**
Facility				
Inpatient Hospital	Part A initial deductible		No member payment	No member payment
Days 1 - 60	$992	$992	No member payment	No member payment
Days 61 - 90	$248 per day	$248 per day	No member payment	No member payment
Lifetime reserve	$496 per day	$496 per day	No member payment	No member payment
Skilled Nursing Facility				
Days 1 - 20	None	None	No member payment	No member payment
Days 21 - 100	$124 per day	$124 per day	No member payment	No member payment
Home Health	None	None		
Hospice Care	Medicare pays most charges. Remaining costs include drug copayment and limited cost for respite care.	Remaining cost	No member payment	No member payment
Physician Services				
Inpatient	20% of Medicare's approved amount and Part B deductible if accepting assignment	100% up to CareFirst allowed benefit	No member payment	No member payment
Emergency	20% of Medicare's approved amount and Part B deductible	100% up to CareFirst allowed benefit	No member payment	No member payment
Surgery	20% of Medicare's approved amount and Part B deductible	100% up to CareFirst allowed benefit	No member payment	No member payment
Laboratory Services	100%	None	No member payment	N/A
Radiology Services	20% of Medicare's approved amount and Part B deductible	100% up to CareFirst allowed benefit	No member payment	No member payment
Office Visit	20% of Medicare's approved amount and Part B deductible	80% up to CareFirst allowed benefit	Balance up to Medicare's approved amount after $100 deductible is met	Balance up to Medicare's limiting charge after $100 deductible is met
Office Therapy				
Radiation/ Chemotherapy	20% of Medicare's approved amount	100% up to CareFirst allowed benefit	No member payment	No member payment
Physical Therapy	20% of Medicare's approved amount and Part B deductible	100% up to CareFirst allowed benefit, 100% visit maximum per calendar year, 80% up to the allowed benefit thereafter	Balance up to Medicare's approved amount after $100 deductible is met	Balance up to Medicare's limiting charge after $100 deductible is met

Harford County Medicare Supplemental Plan

			Member Payment	
Benefits	**Remaining Costs after Medicare Payment**	**CareFirst Plan Payment**	**Provider Accepting Medicare Assignment**	**Provider Not Accepting Medicare Assignment**
Other Services				
Ambulance Services	20% of Medicare's approved amount and Part A/B deductible	80% up to allowed benefit	Balance up to Medicare's approved amount after $100 deductible is met	Balance up to Medicare's limiting charge after $100 deductible is met
Durable Medical Equipment	20% of Medicare's approved amount and Part A/B deductible	80% up to allowed benefit	Balance up to Medicare's approved amount after $100 deductible is met	Balance up to Medicare's limiting charge after $100 deductible is met
Prosthetic Appliances	20% of Medicare's approved amount deductible	100% up to allowed benefit	$100 deductible	$100 deductible
Whole Blood (In full - Part A 3 pint deductible - Part B)	20% of Medicare's approved amount and Part A/B deductible	80% up to allowed benefit	Balance up to Medicare's approved amount after $100 deductible is met	Balance up to Medicare's limiting charge after $100 deductible is met
Medical Supplies	20% of Medicare's approved amount and Part A/B deductible	80% up to allowed benefit	Balance up to Medicare's approved amount after $100 deductible is met	Balance up to Medicare's limiting charge after $100 deductible is met
Mammograms	Pays for one every 12 months	Difference up to Medicare's approved amount or 100% of CareFirst allowed benefit when not covered by Medicare	No member payment	No member payment when Medicare approved. Difference between CareFirst allowed benefit and provider's charge when not Medicare approved.

Medicare Supplemental Plan Notes

- The Medicare deductibles and coinsurance amounts shown are based on 2007 figures. Your benefits will automatically adjust to meet any amounts that change in 2008.

- CareFirst's allowed benefit for services covered by Medicare and CareFirst will not exceed the Medicare approved amount/Medicare limiting charge.

- Medicare does not place a limiting charge on durable medical equipment, therefore the CareFirst allowed benefit will prevail.

- If Medicare benefits are exhausted, or service is not covered by Medicare, CareFirst Medicare Supplemental Plan benefits may be provided.

- Blue Cross and Blue Shield benefits for inpatient hospital services are provided for 120 days per inpatient stay with a 90-day renewal interval. That is, an inpatient stay will be one stay if discharge date and readmission date are not separated by at least 90 days.

- Major Medical benefits supplement Blue Cross Blue Shield benefits by providing coverage for inpatient days in excess of those covered under Medicare/Blue Cross Blue Shield. Additionally, Major Medical covers certain services, such as office visits for an illness, that are not covered under Blue Cross and Blue Shield.

- Reimbursement under Major Medical is subject to an annual deductible of $100 per individual. After your deductible is met, payment is made at 80% of allowed benefit and you pay the coinsurance of 20%. The lifetime benefit maximum is $250,000 per individual. This maximum in no way creates a right to benefits after termination of your CareFirst coverage.

Listed below are examples of Major Medical services:

- Medical office visits
- Medical supplies
- Ambulance services
- Private duty nursing
- Orthopedic and prosthetic devices
- Physical, speech and occupational therapy (in an office or outpatient setting)

These benefits are issued under policies:
13.800 (6/98) • 13.801 (R. 10/99) • 13.802 (R. 10/99) • 13.803 (R. 10/99)
13.804 (R. 10/99) • 13.805 (R. 10/99) • 13.806 (R. 10/99) • 13.807 (R. 10/99)
13.808 (R. 10/99) • 13.809 (R. 10/99) • BCBSMD-APPEAL (1/99)

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